

State of Wisconsin Department of Workforce Development Equal Rights Division Civil Rights Bureau	Retaliation Complaint Employee Right to Know About Toxic Substances or Infectious Agents on the Job (Section 101.58 Wisconsin Statutes)	ERD Case Number (To be entered by the Division)
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Personal information you provide may be used for secondary purposes.

Instructions -- Please Read Before Completing This Form

- Provide all information requested below. **Type or Print In Black Ink.**
- You must sign this complaint **on page 2**, and fill out the Process Information Sheet on **page 3** before submitting your complaint to the Equal Rights Division.

1. Complainant Information	2. Respondent Information
Your First Name	Name of Respondent(s) (The company(s) or organization(s) you believe retaliated against you.) If there is more than one Respondent, fill out this box with information about one Respondent. Use a separate sheet of paper to give the same information about the others and attach to this form.
Your Middle Name	
Your Last Name	
Your Street Address	Respondent Street Address
Your City	Respondent City
Your State	Respondent State
Your Zip Code	Respondent Zip Code
Your Home Telephone Number Including the Area Code ()	Respondent Telephone Number Including the Area Code ()
Your Work Telephone Number Including the Area Code ()	What type of business is the Respondent
May we call you at work? <input type="checkbox"/> Yes <input type="checkbox"/> No	County, in Wisconsin, where you worked
3. What did you do that you believe is protected by law? (For example: "Asked for information about a toxic substance or infectious agent", "refused to work with a toxic substance because information was not received", etc.) Give the date of each action (month/day/year).	
NOTICE REQUIRED UNDER Section 15.04(1)(m), Wisconsin Statutes: Authorization for this form is provided under Section 101.595(2), Wisconsin Statutes. Completion of this form is voluntary. However, if you wish to file a complaint of retaliation with the Equal Rights Division, you must submit a written document containing the information sought by this form. This information is used for the purpose of processing your complaint and maintaining the Equal Rights Division's records.	For Office Use Only

4. If you answered question 3, did you talk, write or send an Email to someone about the toxic substance or infectious agent? ☐ Yes ☐ No

Give the name, title and telephone number of the person you contacted

Give the date of each action.

What exactly did you say?

5. Describe the employment action(s) your employer took because of what you did. (For example: terminated me, disciplined me, demoted me, reduced my hours, etc.) If your employer took more than four employment actions, please describe on a separate sheet of paper and attach to this form.

a. First employment action:

Date taken:

b. Second employment action:

Date taken:

c. Third employment action:

Date taken:

d. Fourth employment action:

Date taken:

6. Certification and Signature

By my signature below, I certify that I have read the above complaint, and, under penalties of law, I declare that this complaint is true and correct to the best of my knowledge and belief.

Signature of complainant or authorized representative

Date signed

Mail Your Completed and Signed Complaint to One of the Following Offices

**State of Wisconsin
Department of Workforce Development
Equal Rights Division**

201 E. Washington Ave., Room A300
PO Box 8928
Madison, WI 53708
Telephone: (608) 266-6860
FAX: (608) 267-4592
TTY: (608) 264-8752

819 North 6th Street
Room 255
Milwaukee, WI 53203
Telephone: (414) 227-4384
FAX: (414) 227-4084
TTY: (414) 227-4081

Equal Rights Complaint Process Information Sheet

Please answer the following questions and return this sheet with your completed complaint. We need this information to effectively process your complaint.

First Name	Middle Name	Last Name
Today's Date	Your Date of Birth (requested for identification purposes) (month/day/year)	
Availability/Contact Information (Important! You must notify the Equal Rights Division if you change your address or telephone number. If we are unable to locate you, your complaint may be dismissed.)		
Is there a telephone number where you can be reached between 7:45 a.m. and 4:30 p.m.? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, provide the telephone number including the area code ()		
Please provide the name, address, and telephone number of a friend or relative who does not reside with you but who will know where you can be reached.		
Name of contact person		Relationship to you
Address		Telephone number including the area code ()
Approximate number of employees at all work locations: <input type="checkbox"/> Less than 15 <input type="checkbox"/> 15-100 <input type="checkbox"/> 101-200 <input type="checkbox"/> 201-500 <input type="checkbox"/> More than 500		
Does another company own the Respondent? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		
If yes, please provide the name of that company		
Complete this section if you were (or still are) employed by Respondent:		
When were you hired?		What is/was your job title?
Are you still employed by the respondent? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Complete this section if you are no longer employed by the respondent:		
How did your employment end? <input type="checkbox"/> Discharged <input type="checkbox"/> Quit <input type="checkbox"/> Laid off <input type="checkbox"/> Retired <input type="checkbox"/> Other		
The date your employment ended	Rate of pay at termination	Hours worked weekly
If you were not promoted, what was the title of the position you applied for?		
Rate of pay		Hours per week
At this time, what are you seeking to settle your complaint?		

You will have an opportunity to provide more information during the investigation

Statistical Information		
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		
Race (check appropriate box or boxes):		
<input type="checkbox"/> American Indian or Alaska Native	<input type="checkbox"/> Native Hawaiian or Pacific Islander	<input type="checkbox"/> Black or African America
<input type="checkbox"/> Asian	<input type="checkbox"/> White	<input type="checkbox"/> Unknown
National Origin or Ethnic background (check one):		
<input type="checkbox"/> Hispanic or Latino	<input type="checkbox"/> Arab, Afghani or Middle Eastern	<input type="checkbox"/> Other